Nevada Provider News

June 2020 Anthem Provider News and Important Updates -- Nevada

Medicare:

Medicaid:

A special thank you to Care Providers

Published: Jun 1, 2020 - **Administrative**

We want to express our most sincere thanks for your dedication to serving the patients in your care. Please take a moment to watch this brief **thank you message** from Anthem.

524-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/a-special-thank-you-to-care-providers-4

UPDATE: New Level of Care Medical Necessity Review of Upper and Lower Endoscopy procedures is delayed

Published: Jun 1, 2020 - **Products & Programs**

Please be aware that the Level of Care Medical Necessity Review of Upper and Lower Endoscopy procedures that was previously announced in the **March 2020** edition of Anthem Blue Cross and Blue Shield (Anthem)'s *Provider News* is delayed until further notice. A new program launch date will be communicated prior to implementation of the review.

Anthem invites you to take advantage of an informational webinar that will introduce you to the Level of Care Review of Upper and Lower Endoscopy procedures and the capabilities of the AIM **Provider***Portal*$_{SM.}$ Visit the **AIM Surgical Procedures microsite** to register for an upcoming training session.

469-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/update-new-level-of-care-medical-necessity-review-of-upper-and-lower-endoscopy-procedures-is-delayed-2

Anthem enhances process for submitting Behavioral Health Authorizations

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Anthem Blue Cross and Blue Shield (Anthem) is excited to announce an enhanced process for submitting behavioral health authorizations. We have enhanced the Interactive Care Reviewer (ICR) tool on the Availity Portal to provide the opportunity for quicker resolutions.

The ICR tool on the Availity Portal will now utilize sophisticated clinical analytics in order to provide an immediate decision on an authorization for higher levels of care such as inpatient, intensive outpatient (IOP) and partial hospitalization (PHP). Here are a few of the many reasons behavioral health providers will benefit from using ICR with the newly enhanced functionality:

1. Reduction of administrative burden
2. Quicker access to care for some services deemed eligible for our immediate decisions
3. Increased member focus
4. Prioritizes more complex cases
5. Reduced possibility of errors such as illegible faxes
6. Maximize the amount time spent with members

Instructions to access ICR through the Availity Portal (www.Availity.com)

1. First, ask your Availity administrator to grant you the appropriate role assignment.

   - **Do you create and submit prior authorization requests?**
   Required role assignment: *Authorization and Referral Request*
   - **Do you check the status of the case or results of the authorization request?**
   Required role assignment: *Authorization and Referral Inquiry*

1. Once you have the authorization role assignment, log onto Availity with your unique user ID and password follow these steps.

   - Select **Patient Registration** from Availity's home page
   - Select **Authorizations & Referrals**
   - Select **Authorizations** *(for requests)* | Select **Auth/Referral Inquiry** *(for inquiries)*

Training:
Follow these instructions to access ICR on demand training through the Availity Custom Learning Center:

- From Availity's home page, select **Payer Spaces | Anthem tile | Applications | Custom Learning Center tile.**
- From the **Courses** screen use the filter catalog, and select **Interactive Care Reviewer – Online Authorizations** from the menu and click **Apply**.

You will find two pages of online courses consisting of on demand videos and reference documents illustrating navigation and features of ICR. Enroll for the course(s) you want to take immediately or save for later.

468-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/anthem-enhances-process-for-submitting-behavioral-health-authorizations

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Quality Corner: Follow-Up after Hospitalization for Mental Illness

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

As a provider, we understand you are committed to providing the best care for our members, including follow up appointments with members after a behavioral health (BH) inpatient stay. Since regular monitoring, follow up appointments and making necessary treatment recommendations or changes are all part of excellent care, we would like to provide an overview of the related HEDIS measure.

The Follow-Up after Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members (6 years and older) who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of behavioral health inpatient discharges for which the member received follow-up within 7 days after discharge.

- The percentage of behavioral health inpatient discharges for which the member received follow-up within 30 days after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are being recommended and scheduled during the inpatient stay as part of discharge planning by the eligible behavioral health facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as practicing behavioral health providers.

Please consider the following for improving member outcomes for this measure:

1. Earliest follow up with a BH provider can help with continuing treatment after leaving the hospital.
2. With greater emphasis on care coordination, primary care providers can help facilitate the BH follow up appointments.
3. Weekend member discharges have shown to have very inconsistent follow up after discharge. Start discharge planning as soon as possible while members are inpatient so those who are discharged on weekends have scheduled follow up appointments.
4. In addition, other social determinants of health pertinent to the member such as housing, food, living in a rural area, transportation, job schedule, family and social support, child care, etc., can impact follow-up opportunities. Please address these needs and issues; refer to resources that can help support the member.
5. Social workers at the facilities can contact Anthem member services to learn if additional sources of assistance are available through Anthem such as case management and other referrals.

Telehealth services have been identified as part of follow up for this HEDIS measure available in certain parts of the country. Telehealth follow up may not be the best choice for everyone; however, not having a BH follow up for several weeks can be detrimental to the member can be a reason for relapse.

440-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/quality-corner-follow-up-after-hospitalization-for-mental-illness-2

Anthem prior authorization updates for specialty pharmacy are available (MAC)

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

Material Adverse Change (MAC)

Anthem prior authorization updates for specialty pharmacy are available

458-0620-PN-CONV

Article Attachments

20200601-458-0620-PN-CONV_MAC - Anthem Prior Auth Update for Specialty Rx - NV rv 20200518 UPDATED final.pdf
application/pdf - 644.35 KB

URL: https://providernews.anthem.com/nevada/article/anthem-prior-authorization-updates-for-specialty-pharmacy-are-available-mac-5

Pharmacy information available on anthem.com

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October).

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

463-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/pharmacy-information-available-on-anthemcom-67

Anthem introduces lower cost Anthem Health Access Plans on June 1 in response to COVID-19 crisis

Published: Jun 1, 2020 - **Administrative**

Like many, Anthem Blue Cross and Blue Shield (Anthem) is closely monitoring COVID-19 developments and what it means for our customers and our health care provider partners. Anthem is working to help employers who are facing tough decisions on furloughing or reducing hours of their workforce. Anthem is doing this by creating health insurance options that provide continued access to care. We continue to seek ways to support our customers by offering affordable alternate products with more flexibility while ensuring members can continue to see their established physicians.

Beginning June 1, 2020, Anthem is introducing our Anthem Health Access Plans for certain large group employers currently enrolled in our commercial lines of business only.

Anthem Health Access Plans cover the diagnosis and treatment for COVID-19 at 100% in accordance with Anthem guidelines.

These benefit plans cover preventive care, unlimited telemedicine, office visits, prescriptions and more. In addition, members enrolled in these plans have digital ID cards and access to Sydney Health and Sydney Care (Anthem's mobile app that runs on intelligence – as part of our digital strategy).

These plans include some coverage exclusions or limitations. For information about eligibility, available benefits, and a list of exclusions, please visit Availity – our Web-based provider tool at www.availity.com.

We are committed to working with our provider partners to help our members focus on their health and well-being. The new Health Access plans give your patients the needed coverage to manage their everyday health needs.

NOTE: *As with all eligibility and benefits inquiries on Availity, providers must have the member ID number (including the three-character prefix) and one or more search options of date of birth, first name and last name.*

520-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/anthem-introduces-lower-cost-anthem-health-access-plans-on-june-1-in-response-to-covid-19-crisis-3

Anthem Commercial Risk Adjustment (CRA) Program Update: Retrospective Program Begins; Prospective Program Continues

Published: Jun 1, 2020 - **Administrative**

Anthem is committed to collaborating with the provider community and offering flexible options to meet the needs of both the retrospective program and the prospective program. The retrospective program focuses on medical chart collection. The prospective program focuses on member health assessments for patients with undocumented Hierarchical Condition Categories (HCC's), in order to help close patients' gaps in care.

Retrospective Chart Requests

We appreciate that care providers across the country on the front line are committed to providing care during these challenging times, and as such, that care results in a visit where we may need the medical chart. Medical chart collection must be done to obtain undocumented HCC's on your patients in order to be compliant with the provisions of the Affordable Care Act, (ACA), that require our company to collect and report diagnosis code data for ACA membership. This process will begin in June.

In order to make these chart requests the most efficient for your office, we have electronic options available:

- EMR Interoperability
- Allscripts (Opt in -- signature required)
- NextGen
- Athenahealth
- MEDENT
- Remote/Direct Anthem access
- Vendor virtual or onsite visit (if the offices are opened back up from COVID-19 closures)
- Secure FTP

The goal of these electronic options is to both improve the medical record data extraction and the experience for Anthem's providers. If you are interested in this type of set up or any other remote access options, please contact the Commercial Risk Adjustment Network Education Representative, Socorro.Carrasco@anthem.com.

Prospective Patient Outreach – $100 or $50 incentive opportunities available
We encourage members to form a relationship with their Primary Care Physician to complete a clinical assessment to ensure you have a clearer picture of your patients' health. Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. Previous Anthem news updates have given telehealth reimbursement guidance to follow when submitting the claim.

- ***Incentive opportunity for properly completed health assessments: Physicians are eligible to receive $100 for electronic submissions, or $50 for paper, in addition to the office visit reimbursement.***

As a reminder, the May 2020 issue of *Provide News* mentioned incentives for prospective program participation ($100 or $50). We would be happy to meet and review incentive opportunities along with other flexible options for program participation and chart collection. Please contact the Commercial Risk Adjustment Network Education Representative, Socorro.Carrasco@anthem.com, to set up a meeting.

Thank you for your continued efforts with the CRA Program.

454-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/anthem-commercial-risk-adjustment-cra-program-update-retrospective-program-begins-prospective-program-continues-3

Availity Portal Notification Center

Published: Jun 1, 2020 - **Administrative**

Anthem Blue Cross and Blue Shield (Anthem) is now using the **Notification Center** on the Availity Portal home page to communicate vital, time sensitive information. A **Take Action**

call out, and a red flag in front of the message, will make it easy to see that there is something new requiring your attention.

The Notification Center is currently being used to notify you if there are payment integrity requests for medical records, or recommended training in the Custom Learning Center. Select the **Take Action** icon to instantly access the custom learning recommended course.

For membership where the disputes tool is available, Availity will also post a message in the notification center when a dispute request you have submitted is finalized. Selecting the **Take Action** icon will allow easy access to your appeals worklist for details.

Viewing the Notification Center updates should be included as part of your regular workflow so you are always aware of any outstanding action items and can respond timely.

457-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/availity-portal-notification-center-4

Quality Corner: CPT® Category II codes – Collaborating for enhanced patient care

Published: Jun 1, 2020 - **Administrative**

The American Medical Association has an alphabetical listing of clinical conditions with which measures and CPT Category II codes are associated. The use of CPT Category II Codes and ICD-10-CM codes can reduce the number of medical records that we request during the HEDIS® medical record review season (January – May each year), thus reducing the administrative burden on physician offices.

Below are some commonly used codes for your convenience.

Measure	Description	CPT II Code	Exclusions
Comprehensive Diabetes Care	Whether or not patient age 18-75 had screening or monitoring for diabetic retinal disease	· **2022F** - Dilated retinal eye exam with interpretation by ophthalmologist or optometrist documented and reviewed with evidence of retinopathy · **2023F** - Dilated retinal eye exam with interpretation by ophthalmologist or optometrist documented and reviewed without retinopathy · **3072F** - Low risk for retinopathy (no evidence of retinopathy in the prior year)	· Documentation of gestational diabetes or steroid-induced diabetes
Comprehensive Diabetes Care	For patient age 18-75, whether or not the most recent A1c level is controlled	· **3044F** - Most recent hemoglobin A1c level less than 7.0% · **3051F** - Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% · **3052F** - Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% · **3046F** - Most recent hemoglobin A1c level greater than 9.0%	· Report one of the four Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. · Documentation of medical reasons for not pursuing tight control of A1c level (i.e., steroid-induced or gestational diabetes, frailty and/or advanced illness)

Comprehensive Diabetes Care	Whether or not patient age 18-75 received urine protein screening or medical attention for nephropathy	· **3060F** - Positive microalbuminuria test documented and reviewed · **3061F** - Negative microalbuminuria test result documented and reviewed · **3062F** - Positive macroalbuminuria test result documented and reviewed · **3066F** - Documentation of treatment for nephropathy	· Documentation of gestational diabetes or steroid induced diabetes
Controlling High Blood Pressure	During the most recent visit, whether or not a patient age 18 years or older with a diagnosis of hypertension had: · a blood pressure reading less than 140 mm Hg systolic and less than 90 mm Hg diastolic **OR** · a blood pressure reading greater than or equal to 140 mm Hg systolic and less than 90 mm Hg diastolic, and prescribed 2 or more anti-hypertensive agents	· **3074F** - Most recent systolic blood pressure < 130 mm Hg · **3075F** - Most recent systolic blood pressure 130 to 139 mm Hg · **3077F** - Most recent systolic blood pressure ≥ 140 mm Hg · **3078F** - Most recent diastolic blood pressure < 80 mm Hg · **3079F** - Most recent diastolic blood pressure 80 – 89 mm Hg · **3080F** - Most recent diastolic blood pressure ≥ 90 mm Hg · **4145F** - Two or more anti-hypertensive agents prescribed or currently being taken	· Report one of the three systolic codes. · Report one of the three diastolic codes. · Documentation of reason(s) for not prescribing 2 or more anti-hypertensive medications: o Medical (i.e., allergy, intolerant, postural hypotension or other reason) o Patient (i.e., patient declined, or other patient reason) o System (i.e., financial or other system reason)

Timeliness of Prenatal Care	Women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery	· **0500F** - Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. (Report also date of visit and, in a separate field, the date of the last menstrual period – (LMP)) · **0501F** - Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the LMP (Note: If reporting **0501F** Prenatal flow sheet, it is not necessary to report **0500F** Initial prenatal care visit)	

Timeliness of Postpartum Care	Number of women in the denominator who had a postpartum visit on or between 21 days and 56 days after delivery. Denominator: Women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year	· **0503F** - Postpartum care visit	

460-0620-PN-CONV

URL: https://providernews.anthem.com/nevada/article/quality-corner-cpt-category-ii-codes-collaborating-for-enhanced-patient-care-4

Updated Escalation Contact List -- Nevada

Published: Jun 1, 2020 - **Administrative**

The Escalation Contact List has been updated and is available online. Please go to **anthem.com**. Select **Providers**. Under the *Communications* heading, select **Contact Us**. Choose **Nevada**, then select **Escalation Contact List**.

483-0620-PN-NV

URL: https://providernews.anthem.com/nevada/article/updated-escalation-contact-list-nevada-1

Transition to AIM Clinical Appropriateness Guidelines -- Rehabilitative Services (MAC)

Published: Jun 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

Material Adverse Change (MAC)

Transition to AIM Clinical Appropriateness Guidelines -- Rehabilitative Services

467-0620-PN-CONV

Article Attachments

20200601-467-0620-PN-CONV_MAC - Transition to AIM CGs - Rehab - NV rv 20200516 final.pdf
application/pdf - 721.93 KB

URL: https://providernews.anthem.com/nevada/article/transition-to-aim-clinical-appropriateness-guidelines-rehabilitative-services-mac-1

Nurse Practitioner and Physician Assistant Service (Professional Reimbursement Policy) -- New (MAC)

Published: Jun 1, 2020 - **Policy Updates** / Reimbursement Policies

Material Adverse Change (MAC)

Nurse Practitioner and Physician Assistant Service (Professional Reimbursement Policy) -- New

470-0620-PN-CONV

Article Attachments

20200601-470-0620-PN-NV_MAC - NP and PA Serv - Prof - NV rv 20200516 final.pdf
application/pdf - 604.99 KB

URL: https://providernews.anthem.com/nevada/article/nurse-practitioner-and-physician-assistant-service-professional-reimbursement-policy-new-mac-1

Modifier use reminders

Published: Jun 1, 2020 - **State & Federal** / Medicare

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Anthem Blue Cross and Blue Shield (Anthem) reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is "above and beyond" or "separate and significant" from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Anthem will publish additional articles on correct coding in provider communications.

ABSCRNU-0127-20 April 2020 509409MUPENMUB

URL: https://providernews.anthem.com/nevada/article/modifier-use-reminders-14

Anthem Blue Cross and Blue Shield (Anthem) working with Optum to collect medical records for risk adjustment

Published: Jun 1, 2020 - **State & Federal** / Medicare

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Anthem will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Additional information, including an FAQ, will be available on the **provider website** at **Important Medicare Advantage Updates**.

* Optum and Ciox Health are independent companies providing medical record review services on behalf of Anthem Blue Cross and Blue Shield.

ABSCRNU-0140-20 April 2020 509218MUPENMUB

URL: https://providernews.anthem.com/nevada/article/anthem-blue-cross-and-blue-shield-anthem-working-with-optum-to-collect-medical-records-for-risk-adjustment-2

2020 Medicare risk adjustment provider trainings

Published: Jun 1, 2020 - **State & Federal** / Medicare

The Medicare Risk Adjustment Regulatory Compliance team at Anthem Blue Cross and Blue Shield offers two provider training programs regarding Medicare risk adjustment and documentation guidelines. Information for each training is outlined below.

Medicare Risk Adjustment and Documentation Guidance (General)

When: Offered the first Wednesday of each month from 1 to 2 pm ET

Learning objective: This onboarding training will provide an overview of Medicare Risk Adjustment, including the Risk Adjustment Factor and the Hierarchical Condition Category (HCC) Model, with guidance on medical record documentation and coding.

Credits: This live activity, Medicare Risk Adjustment and Documentation Guidance, from January 8, 2020, to December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at **https://bit.ly/2z4A81e**.
**Note: Dates may be modified due to holiday scheduling.*

Medicare Risk Adjustment, Documentation and Coding Guidance (Condition specific)

Series: Offered on the third Wednesday of every other month at 12 to 1 pm ET

Learning objective: This is a collaborative learning event with Enhanced Personal Health Care (EPHC) to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.

Credits: This live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from January 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:

- Red Flag HCCs, part one: Training will cover HCCs most commonly reported in error as identified by CMS (chronic kidney disease stage 5, ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, end-stage liver disease) *{Recording will play upon registration.}*

- **https://bit.ly/3ae9znc**

- Red Flag HCCs, part two: Training will cover HCCs most commonly reported in error as identified by CMS (atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation) *{Recording will play upon registration.}*

- **https://bit.ly/3abKg52**

- Neoplasms (*recording link will be available later 2020.)*
- Acute, Chronic and Status Conditions (July 15, 2020)

- **https://bit.ly/2ygZfNR**

- Diabetes Mellitus and Other Metabolic Disorders (September 16, 2020)

- **https://bit.ly/2XQ9hjZ**

- TBD - This Medicare Risk Adjustment webinar will cover the critical topics and updates that surface during the year (November 18, 2020)

- **https://bit.ly/2xxjhUj**

ABSCRNU-0141-20 April 2020 509514MUPENMUB

URL: https://providernews.anthem.com/nevada/article/2020-medicare-risk-adjustment-provider-trainings-14

Diabetes HbA1c < 8 HEDIS guidance

Published: Jun 1, 2020 - **State & Federal** / Medicare

Diabetes is a complex chronic illness requiring ongoing patient monitoring. The National Committee for Quality Assurance (NCQA) includes diabetes in its HEDIS® measures on which providers are rating annually.

Since diabetes HbA1c testing is a key measure to assess for future medical conditions related to complications of undiagnosed diabetes, NCQA requires that health plans review claims for diabetes in patient health records. The findings contribute to health plan Star Ratings for commercial and Medicare plans and the Quality Rating System measurement for marketplace plans. A systematic sample of patient records is pulled annually as part of the HEDIS medical record review to assess for documentation.

Which HEDIS measures are diabetes measures?
The diabetes measures focus on members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following assessments:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (> 9%)
- HbA1c control (< 8%)
- Dilated retinal exam
- Medical attention for nephropathy

The American College of Physicians' guidelines for people with type 2 diabetes recommend the desired A1c blood sugar control levels remain between 7% to 8%.[1]

In order to meet the HEDIS measure *HbA1c control < 8*, providers must document the date the test was performed and the corresponding result. For this reason, report one of the four Category II codes and use the date of service as the date of the test, not the date of the reporting of the Category II code.

To report most recent hemoglobin A1c level greater than or equal to 8% and less than 9%, use 3052F. To report most recent A1c level less than or equal to 9%, use codes 3044F, 3051F and 3052F:[2]

1. If the most recent hemoglobin A1c (HbA1c) level is less than 7%, use 3044F.

2. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 7% and less than 8%, use 3051F.

3. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 8% and less than or equal to 9%, use 3052F.

Continued management and diverse pathways to care are essential in controlling blood glucose and reducing the risk of complications. While it is extremely beneficial for the patient to have continuous management, it also benefits our providers. As HEDIS rates increase, there is potential for the provider to earn maximum or additional revenue through Pay for Quality, Value-Based Services and other pay-for-performance models.[3]

Racial and ethnic disparities with diabetes

It is also important for providers to be aware of critical diabetes disparities that exist for diverse populations.

Compared to non-Hispanic whites:[4]

- African Americans, Hispanics, and American Indian/Alaska Natives have higher mortality rates from diabetes.
- African Americans and Hispanics have higher rates of complications from uncontrolled diabetes, including lower limb amputation and end-stage renal disease.
- More than half of Asian Americans and nearly half of Hispanic Americans with diabetes are undiagnosed.[5]
- Asian Americans are at risk for type 2 diabetes at a lower body mass index (BMI); therefore, diabetes screening at a BMI of 23 is recommended.[6]

Sources include:

- **Diabetes prevalence:**
  - 2015 State Diagnosed Diabetes Prevalence, **https://www.cdc.gov/diabetes/data**.
  - 2012 State Undiagnosed Diabetes Prevalence, Dall et al., “The Economic Burden of Elevated Blood Glucose Levels in 2012”, *Diabetes Care*, December 2014, vol. 37.
- **Diabetes incidence:**
  - 2015 State Diabetes Incidence Rates, **https://www.cdc.gov/diabetes/data**.

- **Cost:**
  - American Diabetes Association, “Economic Costs of Diabetes in the U.S. in 2017”, Diabetes Care, May 2018.
- **Research expenditures:**
  - 2017 National Institute of Diabetes and Digestive and Kidney Diseases funding, **https://projectreporter.nih.gov**.
  - 2017 CDC diabetes funding, **https://www.cdc.gov/fundingprofiles**.

1 https://www.medicalnewstoday.com/articles/321123#An-A1C-of-7-to-8-percent-is-recommended
2 https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf
3 https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html
4 Office of Minority Health. Minority Population Profiles: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlID=26
5 U.S. Department of Health and Human Services, National Institutes of Health. (2015, September 8), More than half of Asian Americans with diabetes are undiagnosed. Retrieved from https://www.nih.gov/news-events/news-releases/more-half-asian-americans-diabetes-are-undiagnosed.
6 ADA; NCAPIP; AANHPI DC; Joslin Diabetes Center Asian American Diabetes Initiative. (2015, September). Screen at 23. Retrieved from http://screenat23.org/wp-content/uploads/2015/10/Screenat23package-1.pdf.

ABSCRNU-0145-20 April 2020 509427MUPENMUB

URL: https://providernews.anthem.com/nevada/article/diabetes-hba1c-8-hedis-guidance-4

Updates to AIM Sleep Disorder Management Clinical Appropriateness Guideline

Published: Jun 1, 2020 - **State & Federal** / Medicare

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health®* (AIM) *Sleep Disorder Management Clinical Appropriateness Guideline*.

***Sleep Disorder Management Clinical Appropriateness Guideline* updates by section:**

- Bi-Level Positive Airway Pressure (BPAP) Devices:
  - Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and alignment with Medicare requirements for use of BPAP
- Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing:
  - Style change for clarity
  - Code changes: none

As a reminder, ordering and servicing providers may submit prior authorization (PA) requests to AIM by:

- Accessing AIM's ***Provider****Portal*$_{SM}$ directly at **providerportal.com**. Online access is available 24/7 to process orders in real time, and is the fastest and most convenient way to request PA.
- Accessing AIM via the **Availity Portal**.*
- Calling the AIM Contact Center at **1-800-714-0040** from 7 a.m. to 7 p.m. ET.

What if I need assistance?
If you have questions related to guidelines, email AIM at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/nevada/article/updates-to-aim-sleep-disorder-management-clinical-appropriateness-guideline-19

Keep up with Medicare news

Published: Jun 1, 2020 - **State & Federal** / Medicare

Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Acquisition of Beacon Health Option
- MCG care guidelines - 24th edition

ABSCRNU-0134-20
ABSCRNU-0136-20

URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicare-news-138

Resources supporting our providers during COVID-19

Published: Jun 1, 2020 - **State & Federal** / Medicaid

This communication applies to Medicaid under Anthem Blue Cross and Blue Shield Healthcare Solutions and Medicare Advantage under Anthem Blue Cross and Blue Shield (Anthem).

Supporting providers and those who deliver care to our members is our top concern during the COVID-19 health emergency. Navigating the rapidly changing information is especially important to us so you can focus on what's important – patient care.

Our provider website will host the most accurate information from Anthem.

Visit the COVID-19 section of the Medicaid provider site: **https://mediproviders.anthem.com/nv/pages/covid.aspx**. Information here includes:

1. Frequently asked questions about changes to Anthem policies or benefit coverage during COVID-19. **These FAQ are updated regularly; please continue to check back each week.** Topics include:
    1. Testing and treatment coverage updates.

2. Telehealth/telephonic care guidance for medical and behavioral health.
3. Coding, billing and claims.

2. Federal resources available for health care providers and employers in the federal *CARES Act*.
3. Other resources as provided by the Department of Health and Human Services.

Commercial plan information
Visit the Commercial *Provider News* site: **https://providernews.anthem.com/nevada**. Information here includes:

1. The *Provider Spotlight* and *Articles* sections with the most recent notifications for Anthem's commercial health plans related to COVID-19 including FAQ about changes to Anthem policies or benefit coverage during COVID-19. T**hese FAQ are updated regularly; please continue to check back each week.**
2. The latest edition of the monthly Provider News publication, published on the first of the month.

Medicare Advantage plan information
Visit the Medicare Advantage Provider site: **https://www.anthem.com/provider/news/archives/?category=medicareadvantage** > and select your state by going to *Change State* in the top right hand corner. Information here is specific to Anthem Medicare Advantage plans, including information about benefit changes and coverage, telehealth options through **LiveHealth Online***, and testing and treatment.

Additional member support information
Anthem's coronavirus website at **https://www.anthem.com/coronavirus** offers additional solutions that can connect members exhibiting symptoms with a doctor, help members understand risk for COVID-19 and find COVID-19 services in their community.

LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/nevada/article/resources-supporting-our-providers-during-covid-19-1

Notification for ambulatory medical record review

Published: Jun 1, 2020 - **State & Federal** / Medicaid

In addition to the annual HEDIS® medical record review, the Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) quality management group conducts ambulatory medical record reviews (AMRR) for compliance with federal, state, accreditation standards and contractual requirements including but not limited to:

- Adherence to *Clinical Practice Guidelines*
- National Committee for Quality Assurance and HEDIS criteria
- Nevada Division of Health Care Financing and Policy
- Early and Periodic Screening, Diagnostic and Treatment (also known as the Nevada Healthy Kids program)

Please refer to the *Program Participating Provider Agreement Sections 3.7*; *3.9*; *4.2* second paragraph;
6.15 (ii); *7.1* for contractual information; and the *Provider Manual — Quality Management Section 10.1* AMRR details.

Ongoing review allows for evaluation and improvements of providers, practices and overall network performance. Anthem clinical quality management nurses will call to schedule an appointment and confirm contact and location information. A list of the members selected for review will be sent via secure fax/email or established SFTP site to help prepare for the medical record review. Once the review is completed, an exit interview will be performed with the provider or practice manager. The results and opportunities for improvement will be sent within three days of the audit to the provider site.

Anthem will conduct a re-audit in six months for providers who score less than 80% to monitor progress towards improvement and those who require a corrective action plan for deficiencies. If the overall score remains below 80% on re-audit, the findings will be presented to the plan's medical director for further action.

If you have any questions regarding your AMRR or its findings, you may contact me directly at **702-228-1308**.

Follow-Up After Hospitalization for Mental Illness

Published: Jun 1, 2020 - **State & Federal** / Medicaid

We understand providers are committed to providing our members with quality care, including follow-up appointments after a behavioral health (BH) inpatient stay. Since regular monitoring, follow-up appointments and making necessary treatment recommendations or changes are all part of quality care, we would like to provide an overview of the related HEDIS® measure.

The Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of BH inpatient discharges for which the member received follow-up within seven days after discharge.
- The percentage of BH inpatient discharges for which the member received follow-up within 30 days after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are recommended and scheduled during the inpatient stay as part of discharge planning by the eligible BH facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as by practicing BH providers.

Please consider the following for improving member outcomes for this measure:

- Earliest follow-up with a BH provider can help with continuing treatment after leaving the hospital.
- With greater emphasis on care coordination, PCPs can help facilitate the BH follow-up appointments.

- Weekend discharges have shown to have very inconsistent follow-up appointments after discharge. Start discharge planning as soon as possible during inpatient stay so those who are discharged on weekends have already scheduled follow-up appointments.
- In addition, facilitate discussion of other social determinants of health (such as housing, food, living in a rural area, transportation, job schedules, family and social support, child care, etc.) which can influence follow-up opportunities. Please address these needs and issues during the behavior health inpatient stay.
- Social workers at the facilities can contact Member Services for Anthem Blue Cross and Blue Shield Healthcare Solutions to learn if additional sources of assistance are available through case management or other referrals.
- Telehealth services may be considered as part of follow-up for this HEDIS measure if permitted in your state for BH follow-up and must be based on your clinical evaluation since this may not be the best choice of follow up for everyone.
    - However, it is also extremely important to note that telehealth services are subject to state and federal policies, coding and other requirements.
    - Please follow required guidelines and policies related to telehealth services specific to this measure.
- Our goal is continuity of care and treatment within seven days of inpatient BH discharge, followed by another visit within 30 days.

Please note this bulletin is for informational purposes only, as a resource for BH HEDIS follow up guidelines.

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URL: https://providernews.anthem.com/nevada/article/follow-up-after-hospitalization-for-mental-illness-5

Keep up with Medicaid news

Published: Jun 1, 2020 - **State & Federal** / Medicaid

Please continue to check Medicaid Provider Communications & Updates at anthem.com/mediproviders for the latest Medicaid information.

- Acquisition of Beacon Health Options
- MCG care guidelines - 24th edition
- 2020 affirmative statement concerning utilization management decisions

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ANV-NU-0124-20
ANV-NU-0125-20

URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicaid-news-30
